Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004686	A. BUILDING _____ B. WING _____	R-C 05/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON HOUSE	2116 BUTLER RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00088036. Complaint IN00088036- Corrected Survey Date: May 16, 2011 Facility number: 0004686 Provider number: 0004686 AIM number: NA Survey team: Christine Fodrea, RN, TC Sue Brooker, RD Census bed type: Residential: 33 Total: 33 Census payor type: Other: 33 Total: 33 Sample: 3 Hamilton House was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00088036. Quality review completed on May 17, 2011 by Bev Faulkner, RN	{R 000}		